

		FOR OFF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>8000267</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Alton Memorial Hospital - SNF</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2005</u> to <u>12/31/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>	
Address: <u>One Memorial Drive</u> <u>Alton</u> <u>62002</u>			
<div>NumberCityZip Code</div>			
County: <u>Madison</u>			
Telephone Number: <u>(314) 463-7301</u> Fax # <u>(314) 463-7850</u>			
IDPA ID Number: <u>37-0661172</u>		<div>Officer or Administrator of Provider</div> <div>(Signed) _____ (Date) _____</div> <div>(Type or Print Name) <u>R.B. McMullen</u></div> <div>(Title) <u>President</u></div> <div>Paid Preparer</div> <div>(Signed) _____ (Date) _____</div> <div>(Print Name and Title) _____</div> <div>(Firm Name & Address) _____</div> <div>(Telephone) <u>()</u> Fax # ()</div> <div>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div>	
Date of Initial License for Current Owners: <u>1/1/71</u>			
Type of Ownership:			
<div><div><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</div><div><input checked="" type="checkbox"/> Charitable Corp.</div><div><input type="checkbox"/> Trust</div></div> <div>IRS Exemption Code _____</div>			
<div><div><input type="checkbox"/> PROPRIETARY</div><div><input type="checkbox"/> Individual</div><div><input type="checkbox"/> Partnership</div><div><input type="checkbox"/> Corporation</div><div><input type="checkbox"/> "Sub-S" Corp.</div><div><input type="checkbox"/> Limited Liability Co.</div><div><input type="checkbox"/> Trust</div><div><input type="checkbox"/> Other _____</div></div> <div><div><input type="checkbox"/> GOVERNMENTAL</div><div><input type="checkbox"/> State</div><div><input type="checkbox"/> County</div><div><input type="checkbox"/> Other _____</div></div>			
In the event there are further questions about this report, please contact: Name: <u>Kenneth Wieduwilt</u> Telephone Number: <u>(314) 653-5317</u>			

Facility Name & ID Number Alton Memorial Hospital - SNF

8000267 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>24</u>	Skilled (SNF)	<u>24</u>	<u>8,760</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>24</u>	TOTALS	<u>24</u>	<u>8,760</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>69</u>	<u>1,225</u>	<u>4,300</u>	<u>5,594</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>69</u>	<u>1,225</u>	<u>4,300</u>	<u>5,594</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 63.86%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? _____

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐

I. On what date did you start providing long term care at this location?
Date started 10/3/86

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 24 and days of care provided 4,300

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Alton Memorial Hospital - SNF # 8000267 Report Period Beginning: 1/1/2005 Ending: Page 3
12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary							238,664	238,664			1
2	Food Purchase		4,404		4,404		4,404		4,404			2
3	Housekeeping		195		195		195	28,348	28,543			3
4	Laundry							37,023	37,023			4
5	Heat and Other Utilities			422	422		422	104,977	105,399			5
6	Maintenance											6
7	Other (specify):*											7
8	TOTAL General Services		4,599	422	5,021		5,021	409,012	414,033			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,048,394	49,465	89,984	1,187,843		1,187,843	152,118	1,339,961			10
10a	Therapy											10a
11	Activities											11
12	Social Services							97,963	97,963			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,048,394	49,465	89,984	1,187,843		1,187,843	250,081	1,437,924			16
	C. General Administration											
17	Administrative							258,728	258,728			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses		18,993	6,675	25,668		25,668	19,812	45,480			21
22	Employee Benefits & Payroll Taxes			77,604	77,604		77,604	249,005	326,609			22
23	Inservice Training & Education											23
24	Travel and Seminar			534	534		534		534			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	TOTAL General Administration		18,993	84,813	103,806		103,806	527,545	631,351			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,048,394	73,057	175,219	1,296,670		1,296,670	1,186,638	2,483,308			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Alton Memorial Hospital - SNF #8000267 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			14,139	14,139		14,139	7,183	21,322			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,555	3,555		3,555		3,555			35
36	Other (specify):*											36
37	TOTAL Ownership			17,694	17,694		17,694	7,183	24,877			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							959,630	959,630			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			15,435	15,435		15,435		15,435			42
43	Other (specify):*							9,863	9,863			43
44	TOTAL Special Cost Centers			15,435	15,435		15,435	969,493	984,928			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,048,394	73,057	208,348	1,329,799		1,329,799	2,163,314	3,493,113			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	2,163,314		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,163,314		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 2,163,314		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
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28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

12/31/2005

[illegible]

Summary B

12/31/2005

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alton Memorial Hospital	100%			Alton Memorial Hospital	Alton, IL.	Management Services

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Alton Memorial Hospital	100.00%	\$ 238,664	\$ 238,664	1
2	V	3	Housekeeping		Alton Memorial Hospital	100.00%	28,348	28,348	2
3	V	4	Laundry		Alton Memorial Hospital	100.00%	37,023	37,023	3
4	V	5	Heat & Other Utilities		Alton Memorial Hospital	100.00%	104,977	104,977	4
5	V	10	Nursing & Medical Records		Alton Memorial Hospital	100.00%	152,118	152,118	5
6	V	12	Social Services		Alton Memorial Hospital	100.00%	97,963	97,963	6
7	V	17	Administrative		Alton Memorial Hospital	100.00%	258,728	258,728	7
8	V	21	Clerical & General Off Exp		Alton Memorial Hospital	100.00%	19,812	19,812	8
9	V	22	Employee Benefits&P/R Taxes		Alton Memorial Hospital	100.00%	249,005	249,005	9
10	V	30	Building Improvement Deprec		Alton Memorial Hospital	100.00%	7,183	7,183	10
11	V	39	Ancillary Services Center		Alton Memorial Hospital	100.00%	959,630	959,630	11
12	V	43	Cafeteria		Alton Memorial Hospital	100.00%	9,863	9,863	12
13	V								13
14	Total			\$			\$ 2,163,314	\$ * 2,163,314	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8	There were no payments to related parties.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Alton Memorial Hospital - SNF # 8000267 Report Period Beginning: 1/1/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							\$				\$	1
2												2
3				Not Applicable.								3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$				\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$				\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

\$

1

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$

2

3. Under or (over) accrual (line 2 minus line 1).

\$

3

4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)

\$

4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$

5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$

6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$

7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2000

8

2001

9

2002

10

2003

11

2004

12

FOR OHF USE ONLY

13

FROM R. E. TAX STATEMENT FOR 2004

\$

13

14

PLUS APPEAL COST FROM LINE 5

\$

14

15

LESS REFUND FROM LINE 6

\$

15

16

AMOUNT TO USE FOR RATE CALCULATION

\$

16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alton Memorial Hospital - SNF COUNTY Madison

FACILITY IDPH LICENSE NUMBER 8000267

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>Not Applicable.</u>		\$	\$
2. <u></u>		\$	\$
3. <u></u>		\$	\$
4. <u></u>		\$	\$
5. <u></u>		\$	\$
6. <u></u>		\$	\$
7. <u></u>		\$	\$
8. <u></u>		\$	\$
9. <u></u>		\$	\$
10. <u></u>		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 6,467
- B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1
- C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

- F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 1,352	1
2					2
3	TOTALS			\$ 1,352	3

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9		
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	SNF Wing Project			1985	2,772					2,772	9	
10	New Stairs			1989	8,805					8,805	10	
11	Vacuum Cleaning System			1989	868					868	11	
12	A/C Project			1989	35,590	1,780	20	1,780		29,362	12	
13	Floor Finishes			1996	14,700	1,470	10	1,470		13,475	13	
14	Replace Doors in 15 Patient Rooms			1996	10,618	708	15	708		6,489	14	
15	Renovate Countertops			1999	7,170	358	20	358		2,209	15	
16	Paint Wall Coverings			1999	1,511					1,511	16	
17	Renovate Tackboards			1999	846	106	8	106		653	17	
18	Renovate Doors/Frames			1999	1,713	114	15	114		704	18	
19	Renovate Vinyl Floor			1999	18,823	1,882	10	1,882		11,607	19	
20	Renovate Electrical			1999	13,778	765	18	765		4,719	20	
21	Renovate A/C			1999	2,698					2,698	21	
22	Renovate Drapes			1999	22,658					22,658	22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$142,550	\$7,183		\$7,183	\$	\$108,530	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$155,775	\$13,805	\$13,805	\$		\$109,663	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	79,422	334	334			79,422	73
74								74
75	TOTALS	\$235,197	\$14,139	\$14,139	\$		\$189,085	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$379,099	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$21,322	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$21,322	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$297,615	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
-
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$
-
- Description:
-

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
COMMUNITY COLLEGE
HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts		Not Applicable.			#VALUE!		9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$	#VALUE!	\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 41,861,173	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		12,707,984	3
4	Supply Inventory (priced at)		588,178	4
5	Short-Term Investments			5
6	Prepaid Insurance		306,571	6
7	Other Prepaid Expenses		163,917	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		3,481,627	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 59,109,450	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		525,000	12
13	Land		191,222	13
14	Buildings, at Historical Cost		70,101,883	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		36,490,992	16
17	Accumulated Depreciation (book methods)		(71,290,481)	17
18	Deferred Charges		3,269,407	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		65,266,152	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 104,554,175	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 163,663,625	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 1,220,014	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		5,162,633	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		107,500	33
34	Deferred Compensation		162,670	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Current Liabilities</u>		8,542,971	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 15,195,788	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		17,999,976	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Self Insurance Liability</u>		3,768,099	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 21,768,075	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 36,963,863	46
47	TOTAL EQUITY(page 18, line 24)	\$ 126,699,762	\$ 126,699,762	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 126,699,762	\$ 163,663,625	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 106,893,701	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 106,893,701	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(501,067)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) AMH Net Income	20,281,226	15
16	Other (describe) Change in Restricted Fund Assets	25,902	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 19,806,061	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 126,699,762	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alton Memorial Hospital - SNF # 8000267 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,735,155	1
2	Discounts and Allowances for all Levels	(4,743,109)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,992,046	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,992,046	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	414,033	31
32	Health Care	1,437,924	32
33	General Administration	631,351	33
	B. Capital Expense		
34	Ownership	24,877	34
	C. Ancillary Expense		
35	Special Cost Centers	984,928	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,493,113	40
41	Income before Income Taxes (line 30 minus line 40)**	(501,067)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (501,067)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,256	20,814	565,115	27.15	3
4	Licensed Practical Nurses	10,074	11,628	202,136	17.38	4
5	CNAs & Orderlies	14,934	18,165	202,199	11.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,883	2,230	21,473	9.63	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator	78	87	3,255	37.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,521	4,549	54,216	11.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	47,746	57,473	\$ 1,048,394 *	\$ 18.24	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
			\$	Workers' Compensation Insurance	\$	IDPH License Fee	\$		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment			
				FICA Taxes	77,604	Health Care Worker Background Check			
				Employee Health Insurance		(Indicate # of checks performed)			
				Employee Meals					
				Illinois Municipal Retirement Fund (IMRF)*					
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$						
B. Administrative - Other									
Description			Amount			Less: Public Relations Expense	()		
			\$			Non-allowable advertising	()		
						Yellow page advertising	()		
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 77,604	TOTAL (agree to Sch. V, line 20, col. 8)	\$		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount	
C. Professional Services							Out-of-State Travel	\$	
Vendor/Payee	Type		Amount						
			\$				In-State Travel		
							Seminar Expense	534	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 534	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL					
(If total legal fees exceed \$2500 attach copy of invoices.)			\$						

* Attach copy of IMRF notifications

**See instructions.

(See instructions.)

[illegible]

Facility Name & ID Number Alton Memorial Hospital - SNF

8000267

Report Period Beginning: 1/1/2005

Ending: 12/31/2005

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5-10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,714 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 15,435
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? no Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? n/a
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Ernst & Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. Audit part of BJC HealthCare
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.